VIRGINIA DEPARTMENT OF SOCIAL SERVICES
AUXILIARY GRANT PROGRAM
PROVIDER/DSS COMMUNICATION FORM

AG Case Number:_____ Provider Name_____

Recipient Name:_____SSN:_____DOB:_____

Address:_____

Medicaid ID:_____

Section I - Provider Completes This Section

Patient Status (Complete Appropriate Blocks. (Report any admission, discharge, and/or change in patient status.)

Patient admitted to this assisted living facility/adult foster care home on _____(date)

Level of care: ☐ Residential ☐ Assisted Living

Patient discharged or expired on _____(date)

Discharged to: ☐ Home ☐ Hospital ☐ Other Facility ☐ Expired

☐ Case is in need of an assessment

☐ Patient's income or deductions have changed

☐ Other: Explain_____

Prepared by Name:_____ Title:_____

Telephone:_____ Date:_____

Section II - DSS Completes This Section

Eligibility Information:

☐ Auxiliary Grant approved beginning _____(date)

☐ Medicaid approved beginning _____(date)

☐ Auxiliary Grant denied effective _____(date)

☐ Ineligible for Auxiliary Grant from_____to_____due to a resource transfer.

Approved AG Rate

NOTE: ALF/AFCH providers cannot collect more than the AG rate from the patient. Any income received by the patient in excess of the AG rate is to be retained by the patient. The amount a patient will normally retain will exceed his/her personal needs allowance.

ALF/AFCH Rate: _____ for month of _____ .

ALF/AFCH Rate: _____ for month of _____ .

Worker Name:_____ Agency Name:_____

Agency Address: _____

Telephone:_____ **Date:**_____

PROVIDER/DSS COMMUNICATION FORM
Instructions

PURPOSE OF FORM--To allow the local DSS and the assisted living facility or adult foster care home provider to exchange information regarding:

1. The AG and Medicaid eligibility status of a patient;
2. The amount of income an eligible patient must pay to the provider toward the cost of care;
3. Admission or discharge of a patient to home, hospital, another ALF/AFCH, or an institution, or to report the death of a patient;
4. Other information known to the provider that might cause a change in the eligibility status.

USE OF FORM--Initiated by either the local DSS or the provider of care. The local DSS must complete the form for each applicant at the time initial eligibility is determined. A new form must be prepared by the local DSS whenever there is any change in the patient's circumstances that results in the patient's ineligibility.

The provider must use the form to show admission date, to request an AG or Medicaid eligibility status, to request a Medicaid recipient I.D., to notify the local DSS of changes in the patient's circumstances, of discharge or death.

NUMBER OF COPIES--Original and one copy.

DISTRIBUTION OF COPIES--Send the original to the facility and file the copy in the eligibility case folder.

INSTRUCTIONS FOR PREPARATION OF THE FORM -- Complete the heading with the name of the AG Case Number, Provider Name, Recipient Name, Social Security Number, Date of Birth, the address, and Medicaid I.D. Number.

Section I is for the provider to complete. Section II must be completed by the local DSS. Fill in the appropriate spaces.

Section II - Eligibility Information:

1. Check the first block on an initial form sent in conjunction with the approval of a new Medicaid application, showing the effective date of the Auxiliary Grant.
2. Check the second block if the individual is eligible for Medicaid.
3. Check the third block if the Auxiliary Grant was denied.
4. Check the fourth block if ineligible for AG due to transfer of resources. Dates of disqualification must be listed on the form.

AG Rate:

Enter the amount of the ALF/AFCH rate, and month and year in which the rate is effective.

Fill in Worker Name, Agency Name, Telephone Number and Date the form was completed.